

"Hospital Medical Staffing: Achieving a Balance" Government announces plan for action

On 27 October the government published *Hospital Medical Staffing: Achieving a Balance: Plan for Action*.^{*} The outcome of a year's discussions between teams from the Department of Health and Social Security and the Joint Consultants Committee, with a representative from regional health authority chairmen and from academic medicine, the report plans a ten year improvement in training arrangements and career prospects for hospital doctors. Announcing the plan to the House of Commons, the Minister for Health, Mr Tony Newton, who had chaired the steering group, said that "the purpose of the reforms is to improve the quality of care doctors will be giving to their patients, by increasing the extent to which fully trained doctors are involved in direct patient care . . . and by making a career in the hospital service more secure and therefore more attractive."

Described by the BMA as a watershed, the report would, said the association, "remove many of the frustrations which doctors in the training grades experience and will provide them with satisfying careers at the level of proficiency which they seek." It would also provide patients and health authorities with the "quality and quantity of service" required. The BMA sees the strong and effective role of the Joint Planning Advisory Committee (with its revised reference terms) and the newly restructured regional manpower committees as the key to the implementation plan, which would also remove the bottleneck in junior doctors' training.

Presenting the proposals to the Joint Consultants Committee on 27 October the chairman, Mr A H Grabham, who had led the profession's team, said that the proposals were the best and the most realistic that were achievable at this stage. Technically the report was not out for consultation but a machinery for continuous and regular review had been built in, and a new monitoring group would be set up with representatives of the Central Manpower Committee, the Welsh Office, and the Department of Health.

Hospital Medical Staffing: Achieving a Balance was published in July 1986 as a consultative document issued on behalf of the United Kingdom's health departments, the Joint Consultants Committee, and the chairmen of regional health authorities.

The proposals it contained stemmed from an invitation in October 1985 from the then Minister for Health—now Sir Barney Hayhoe—to the committee and the regional chairmen to join him in investigating the problem of hospital medical staffing. After a period for consultation with interested parties including the profession the ministerial steering group restarted work in October 1986 and with the help of a technical subgroup and an academic and research subgroup it prepared a *Plan for Action*, a 95 page report containing details of the new arrangements for England. An annex gives details for Wales, and the principles of the agreement will apply to Scotland and Northern Ireland.

In a foreword to the report Mr Tony Newton, Minister for Health, Mr A H Grabham, chairman of the Joint Consultants Committee, and Sir Gordon Roberts, for the regional chairmen say that the response to consultation had shown anxieties over some aspects but "an almost universal recognition of the problem and of the need to act, and a widespread degree of support for the main proposals . . . nor has any alternative strategy that would command the wide support of the NHS and of the profession been put forward." They saw action along the lines proposed (see box) as the essential foundation if the hospital staffing structure was to adapt in a way which would "continue to attract the doctors our hospitals need and thus ensure the quality of service our patients rightly expect." They see the proposals from this joint venture as the first opportunity for many years to effect agreed reforms and "look forward to the full cooperation of all concerned—in putting them into practice."

The report opens with the new arrangements described in outline, and this section is given in full below. A section giving the

Principal needs for satisfactory manpower structure

- An increase in the number of consultants to provide the leadership and the career opportunities an expanding service requires
- Sensible planning of the number of doctors in training grades, taking account of career prospects
- Maintenance of necessary levels of support for consultants, particularly in acute specialties.

background and origin of the joint exercise follows in the report, which then goes on to describe the response to the consultation exercise. Section C of the report, extracts from which are at p 1154, gives the detailed arrangements for consultant expansion and for the support grades. Annexes cover manpower projections, plans for Wales, and arrangements for honorary registrars.

Implementation has already started and further key steps will be well under way by the end of 1988.

Outline of new arrangements

(1) Consultant expansion

(1.1) Maintenance by health authorities of existing rates of consultant expansion in line with plans already produced by them. Authorities' performance will be closely monitored both by the DHSS and by the steering group for implementation (paras 1-2†). In addition to this underlying rate of expansion:

(1.2) 100 new additional consultant posts over two years in general medicine, general surgery and traumatic and orthopaedic surgery, 45 of which have already been allocated in 1987-8, with the remaining 55 for allocation in 1988-9 (paras 3-5).

(1.3) Mechanisms for converting registrar and senior registrar posts surplus to training requirements to provide further consultant posts where this is justified on service grounds (paras 6 and 7).

(2) Early and partial retirement

Schemes for early and partial retirement for consultants, at their request and at management discretion, to facilitate the proposed changes to the staffing structure (paras 8-10).

(3) Senior registrars

A continuation of the present joint planning system for senior registrars, setting quotas for each region which will relate the number of posts more closely to expected consultant opportunities (para 12).

(4) Registrars

(4.1) Designation of registrars as "career" (eligible to seek a

^{*}DHSS publication available from Room 411A, Eileen House, 80-94 Newington Causeway, London SE1 6EF.

†Paragraph numbers refer to section C of the report.

career in the United Kingdom) or "visiting" (overseas doctors due to return to their own country in due course) (para 11).

(4.2) An extension of the remit of the Joint Planning Advisory Committee (JPAC) already undertaking the joint planning of senior registrar numbers to set quotas for career registrars, thereby relating the number of registrar posts available to senior registrar numbers and in turn to the number required for the training of future consultants (para 12).

Registrar contracts to be held formally at region, unless in exceptional circumstances the region and the regional committee for hospital medical services have agreed otherwise and that agreement has been ratified by the steering group for implementation (para 27).

(5) Overall reduction in registrar posts

Arrangements for an overall reduction in registrar numbers, where possible by conversion of posts surplus to training requirements to consultant posts (para 28).

(6) Senior house officers

(6.1) A controlled relaxation of the present ceilings on numbers of senior house officers to allow adequate time for training at this grade; and arrangements to monitor the supply and demand for senior house officers to enable ceilings to be adjusted as necessary (paras 29-32).

(6.2) A system of careers advice and counselling for all senior house officers shortly after entering the grade and regularly thereafter (paras 33-6).

(6.3) A recommendation to the doctors' and dentists' review body that there should be one further incremental point to the senior house officer scale from 1 April 1988 and a firm commitment to recommend addition of another point from 1 April 1989 (para 37).

(7) Support grades

(7.1) Staff grade

Introduction of a new non-training career grade to provide a secure career for the small minority of doctors who do not wish to or are unable to progress to the consultant grade. The grade will be subject to strict manpower controls on take up and use and will be monitored closely by the health departments and the steering group (paras 38-47).

(7.2) Associate specialists

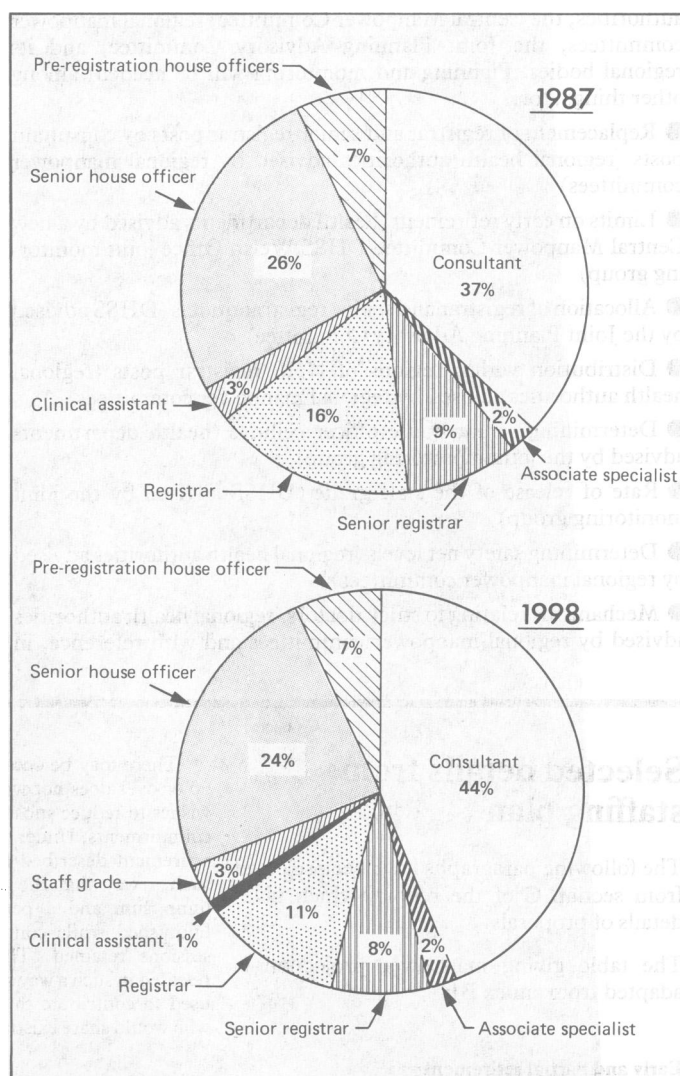
Arrangements for regrading from staff doctor to associate specialist, to include further discussions between health departments, regional health authorities and the Joint Consultants Committee on the possibility of devolving this to regions. Arrangements are also set out for any doctors in the associate specialist grade wishing to seek regrading to staff doctor (paras 48-54).

(7.3) Clinical assistants

After the introduction of the staff grade, no further paragraph 94 (clinical assistant) appointments of six sessions or more. (Doctors now holding such appointments will be allowed to remain in post under the terms of their existing contracts.) The position of general practitioner para 94 appointments remains unchanged (para 55).

(8) Safety net

Newly appointed consultants in the acute specialties will be expected to accept a greater direct involvement in patient care and in



Hospital staffing structure: projected changes 1987-98.

the direct supervision and training of their junior staff. Staff in support of consultants in acute specialties should not be reduced below an acceptable number at an intermediate level of experience. Health authorities, on the advice of the regional manpower committee, will therefore be expected to carry out by 30 September 1989 a review of staffing levels needed to provide 24 hour emergency cover for each acute site (paras 56-62).

(9) Doctors unlikely to make further progress

Mechanisms to identify doctors unlikely to make further progress ("stuck doctors"), to provide counselling and help in obtaining secure employment. In the first instance, this may be by means of a single four year extension of the contract, followed by retraining for another specialty or for general practice, appointment to a staff grade post, regrading as an associate specialist, or, exceptionally, the granting of a five year rolling contract (paras 63-7).

(10) Local and central planning and controls

The steering group for implementation and its technical sub-group will continue to monitor all aspects of the *Achieving a Balance* package carefully. In addition to this the new arrangements call for a variety of mechanisms for planning and control (paras 68-71), involving the health departments, regional and district health

authorities, the Central Manpower Committee, regional manpower committees, the Joint Planning Advisory Committee, and its regional bodies. Planning and monitoring will be needed, among other things, for:

- Replacement of registrar and senior registrar posts by consultant posts (regional health authorities advised by regional manpower committees)
- Limits on early retirement (health departments advised by a new Central Manpower Committee/DHSS/Welsh Office joint monitoring group)
- Allocation of registrar and senior registrar quotas (DHSS advised by the Joint Planning Advisory Committee)
- Distribution within regions of NHS registrar posts (regional health authorities advised by regional manpower committees)
- Determining senior house officer ceilings (health departments advised by the joint monitoring group)
- Rate of release of the staff grade (DHSS advised by the joint monitoring group)
- Determining safety net levels (regional health authorities advised by regional manpower committees)
- Mechanisms relating to stuck doctors (regional health authorities advised by regional manpower committees and with reference, in

some circumstances, to DHSS advised by the Central Manpower Committee).

(11) Unification of registrar and senior registrar grades

The steering group reaffirms its view that, as a desirable long term aim, the average length of time spent in the registrar and senior registrar grades should be reduced. At some stage in the future this reduction might reach the point at which the two grades could be combined into a single higher training grade (para 72).

(12) Timetable for implementation

Implementation began with the first round of the pump priming scheme for consultant expansion. Further key steps will be the extension of the joint planning arrangements to the registrar grade, and the issuing of career registrar quotas, the setting up of the reconstituted regional manpower committees, the phased introduction of the intermediate service grade, and the regional reviews of safety net levels. All these should be well under way by the end of 1988 (paragraphs 73 and 74). But completion of the programme of structural change will take many years.

Selected details from staffing plan

The following paragraphs have been selected from section C of the report, which gives details of proposals.

The table giving manpower projection is adapted from annex B1.

Early and partial retirement

"Individual consultants who wish to be considered for early retirement should, at least a year in advance, begin discussing with management the possibility of the projected retirement. Officers of the regional health authority or special health authority will then draw up a list of proposed early retirements which are agreed both by the consultants concerned and by management. Management must be prepared to certify that the retirement would advance the structural changes required in the medical staffing structure, and would be in the interests of the service. They must also confirm that the retiring consultant will be replaced by another consultant.

"The agreed list will be submitted to the DHSS in November in respect of proposed early retirements for the following financial year. (Details of arrangements in the first year of operation will be sent to health authorities as soon as possible.) The list will show the specialty and age (but not the name) of the consultants concerned.

"The DHSS will examine the proposals and adjust them if otherwise the national limit would be exceeded, either in individual specialties or overall.

"The adjusted figures will then act as control totals for each regional health authority and special health authority. Authorities will be allowed to substitute one individual for another within the same specialty, but DHSS approval will be required for any switch between specialties or additional proposals. Authorities will be asked to surrender any permissions which they no longer wish to use.

"There may be occasions when a consultant of 60 or over does not wish to retire completely but wishes to reduce substantially his or her sessional commitments. Under the arrangements for partial retirement described below this can be done in such a way that the consultant draws a partial lump sum and a pension for the sessions relinquished while continuing to be paid for the sessions retained. The health authority funds released in such a way should where appropriate be used to contribute to funding a new consultant, who would share existing facilities and junior staff.

Registrar posts

"On implementation of *Achieving a Balance* all newly appointed registrars will be designated as 'career' or 'visiting' registrars. Career registrars are those who are eligible to pursue a career in the UK (see below). Regions will be given 'quotas' for career registrars in each specialty and will be expected to make appointments to registrar posts in such a way that the number of career registrars in post in each specialty does not exceed the quota. For the time being there will be no national restrictions on the number of visiting registrars, but the position will be kept under review.

"Quotas will be determined by the DHSS on advice from the Joint Planning Advisory Committee, who will continue their work on senior registrar quotas, but whose remit and membership have been extended to enable it to undertake registrar quotas. In most specialties, these quotas will represent substantial reductions compared with the number of UK graduates now in the grade. It is envisaged that an interim quota will be set for achievement within five years and a final quota for ten years, although the timescale may differ between specialties. Regions will be allowed discretion to manage the rate of progress towards these quotas in the light of local circumstances, but should in no circumstances allow the number of UK graduates to rise above the number in post at 30 September 1987 for specialties in which a reduction is required.

"Separate allocations will be made, again on advice from the Joint Planning Advisory Committee, for university teaching posts (that is,

established academic lecturer posts, with University Grants Committee or other long term funding) and for research posts with honorary registrar contracts. These will also be progressively reduced at a similar rate of reduction to NHS posts. In framing its advice on the regional distribution of honorary posts and on the detailed allocation of research posts, the Joint Planning Advisory Committee will be advised by an academic and research subgroup. Details of the arrangements for honorary posts will be published in the very near future in a joint statement by the DHSS, the JCC, the Committee of Vice Chancellors and Principals of the universities of the United Kingdom, and research interests.

"Registrar posts should wherever practicable be linked into rotations. These rotations will, as far as possible, include experience in both university and district general hospitals, and good existing rotations of this kind should not be disturbed.

"It is not intended that regions should make a distinction between those posts suitable for career registrars and those for visiting registrars. Indeed, it is desirable that career and visiting registrars should wherever possible be on the same rotations. Where it is impracticable for a post to be linked into a rotation, it should in all but the smallest specialties be 'grouped' for manpower planning purposes with one or more other unlinked posts in such a way that each of the posts is filled on some occasions by a visiting registrar and on others by a career registrar. But however regions elect to stay within their quotas, all registrar posts must be of comparable educational value and carry appropriate royal college approval.

Honorary registrar posts

"Although the basic principles set out above apply equally to honorary registrar posts (whether teaching or research) we were concerned to retain some flexibility in order to respond quickly to unforeseen academic needs. The number of academic and research posts will therefore be reduced broadly in the same proportion as applies to NHS posts, but these reductions will be separately identified. One half of each year's reduction will then be retained in a central reserve pool of

honorary posts, from which posts can be allocated by the Joint Planning Advisory Committee (on advice from its academic and research subgroup) in response to exceptional circumstances. This scheme will maintain an adequate level of flexibility while allowing any posts so allocated to be recouped in future years in the overall planning system.

"All UK graduates who intend to pursue a career in the hospital service will be expected to spend at least two years in career registrar posts carrying a substantial clinical component. Academic appointments with honorary registrar status can count towards this period, provided they have a suitable clinical component. However, all honorary posts occupied by UK doctors (as defined above) will be counted against the career registrar quotas, whether they have a clinical element or not, as all are potential candidates for NHS consultant appointments at some stage. The Joint Planning Advisory Committee will take account of such posts in estimating the total number needed.

Senior house officer grade

"Achieving a Balance recognised that the effect of the proposals on the registrar grade might lead to an increase in the average time spent in the senior house officer grade. It was suggested that a modest increase in senior house officer numbers should be allowed to accommodate this, of the order of 750 posts nationally spread over 10 years.

"The precise increase and its phasing need to be carefully judged in the light of evidence that the supply of senior house officers is scarcely adequate to fill existing posts. We therefore agreed that there should be no relaxation of the current senior house officer ceilings until the registrar reductions are under way, and until there is evidence that the predicted increase in the average time in grade (and thus in the available supply) is in fact occurring. As an exception, regions will be allowed discretion to convert a registrar to a senior house officer post where that is the preferred outcome of the review of the registrar post.

"Achieving a Balance noted that it might be necessary to consider a lengthening of the incremental pay scale for senior house officers, who may spend longer in training in the grade or find it necessary to change specialties before successfully applying for career registrar posts. It will be for the doctors' and dentists' review body to advise on this, but the BMA and health departments have agreed to present joint evidence recommending the addition of one further incremental point with effect from 1 April 1988, and have given a firm commitment to recommend the addition of a further increment from 1 April 1989.

Staff grade

"The staff grade (referred to as 'intermediate service grade' in *Achieving a Balance*) is a non-training grade intended for doctors who do not wish or are unable to train for consultant status. The agreed basis of the contract is set out in detail in annex C5, but the underlying principle is that doctors in the grade should be used only on duties in which they will be working for substantially the whole time while on duty. Doctors in the staff grade are therefore unlikely to be used either in specialties which involve a continuously intensive work commitment while on out of hours duty or in areas of work in which there is little need for out of hours cover.

"In *Achieving a Balance* the requirement proposed for entry to the new grade was a minimum of three years' experience in the senior house officer

or registrar grades or as a clinical assistant, with a longer period being the norm. The doctor would normally have received appropriate general professional training during this time, in addition to adequate training in the relevant specialty. Although the qualifications and experience of doctors appointed to staff grade posts will vary, they should all—when they first take up post—be at least capable of carrying out the kind of workload that is normally expected of an experienced senior house officer or first year registrar in that specialty. In all the tasks and duties of the post, the staff doctor will

"The first step in the review might be to look at the number of support staff likely to be available in say 10 years' time in the following categories: senior house officers with experience appropriate to the specialty, registrars (both career and visiting), senior registrars, and practitioners in the staff grade. It is recognised that, at this stage, definitive quotas of staff doctors and career registrars will not have been allocated so far in advance, but regional health authorities will be given indicative assumptions on which to work. Similarly, indicative projections of national trends in the supply of

Projections of the hospital staffing structure in England and Wales*

	"Package" projection				"Do nothing" projection			
	1987	1993	1998	Growth 1987-8 (%)	1987	1993	1998	Growth 1987-8 (%)
Consultant	14 730	17 288	19 473	+32	14 730	15 573	18 098	+23
Associate specialist	850	904	935	+10	850	895	859	+1
Senior registrar	3 400	3 400	3 400	0	3 400	3 400	3 400	0
U K registrar	3 900	3 550	3 300	-15	3 900	4 200	4 350	+12
Overseas registrar (before 1985)	1 650	300	—	-26	1 650	300	—	-7
Overseas registrar (after 1985)	700	1 450	1 450		700	1 450	1 450	
Staff grade	—	1 000	1 500	+62	—	—	—	—
Non-GP clinical assistant	1 130	630	330		1 130	1 492	1 878	+66
Senior house officer	10 320	10 588	10 847	+5	10 320	10 800	11 200	+9
Preregistration house officer	2 980	2 980	2 980	0	2 980	2 980	2 980	0
Total	39 660	42 090	44 215	+11	39 660	42 090	44 215	+11

*Projections are numbers of doctors at 1 April in the years shown except for clinical assistants, where the projection is of whole time equivalents.

be clinically responsible to a nominated consultant.

"The steering group considered the suggestion made in the response to consultation that the entry requirement to this grade should be a higher qualification. We consider that it would be wrong to be too prescriptive and that it is best left to the appointments committee to decide the necessary qualifications in each case. We must repeat though that three years in the senior house officer grade (or equivalent) is the minimum requirement for entry to the grade and that, in most cases, this minimum will be exceeded.

"The steering group recommends phasing the introduction of the grade at a rate of 200 per annum for England and Wales in the first five years and 100 per annum thereafter. Decisions on the number of posts to be released each year in England will be taken by DHSS on advice from the joint monitoring group. 80% of the total posts available will be allocated to regions, who will allocate in turn to districts as appropriate. The remaining 20% will be held in a central reserve.

Safety net

"The primary aim of the 'safety net' review will be for health authorities to establish on a consistent basis within each region, and subject to a realistic assessment of staff likely to be available, what support staff they are likely to need to provide 24 hour cover in the acute specialties. Varying patterns of delivery (for instance supradistrict or supraregional services) make it difficult to specify exactly what specialties should be covered, but we would expect them at least to include the following: general medicine, general surgery, traumatic and orthopaedic surgery, obstetrics and gynaecology, paediatrics, and anaesthetics.

overseas graduates will be available, and regional health authorities will need to consider the supply likely to be available locally.

"Having established the total numbers likely to be available regionally in each specialty, the regional health authorities will need to go on to consider how they might best be deployed across districts so as to give consistent standards of 'safety net' cover across the region. It will clearly be necessary to examine carefully the local factors which might justify having different numbers or grades of staff in different districts—for example, workload indicators and split site working. A pilot study is being carried out in three regions and further guidance may be issued if methods of general applicability are developed from this.

Stuck doctors

"Employing authorities would be asked to identify all doctors at risk of becoming stuck—for example, by applying the time in grade criteria set out above—and should ensure that they receive careers counselling. This might be carried out by the clinical tutor, the district specialty tutor, or by a nominee of the regional postgraduate dean (preferably from outside the district). Where the counsellor concluded that the doctor was unlikely to make further career progress, this advice would—subject to the doctor's own agreement—be conveyed to the district health authority and to the doctor's consultant. The district health authority (with the consent of the doctor and the consultant) would then consider whether it wished to retain the doctor's services at the end of the current contract, and if so would prepare a case for personal appointment in the existing post or in a related post in the district, to be submitted to the regional health authority."